SPINE & SCOLIOSIS SPECIALISTS
ADVANCED TREATMENT & SURGERY

2105 Braxton Lane, Suite 101 • Greensboro, NC 27408
4590 Premier Drive • High Point, NC 27265
Phone: (336) 333-6306 • Fax: (336) 333-6309

NEW ORTHOPAEDIC ASSESSMENT

Name: _____ DOB:_____

1. When did the problem start?_____
2. Were you seen at ER? ❑ Yes ❑ No If yes, which one? _____
3. Did you have surgery for this problem? ❑ Yes ❑ No
4. Location of problem:

Shoulder	❑ R ❑ L	Elbow	❑ R ❑ L	Hand	❑ R ❑ L	Pelvis	❑ R ❑ L	Knee	❑ R ❑ L	Foot	❑ R ❑ L
Arm	❑ R ❑ L	Wrist	❑ R ❑ L	Finger	❑ R ❑ L	Hip	❑ R ❑ L	Ankle	❑ R ❑ L	Toe	❑ R ❑ L

5. Check the box that best fits how your problem started.

❑ No injury

❑ Injury (not auto or work) Date of injury: _____

How did it happen?_____

_____

❑ Injury at work Date of injury: _____

How did it happen?_____

_____

❑ Auto Accident Date of injury: _____

6. Please check the words that best describe your pain:

❑ Aching ❑ Burning ❑ Dull ❑ Numbness ❑ Sharp ❑ Shooting ❑ Stabbing
❑ Throbbing ❑ Cramping ❑ Radiating ❑ Stinging ❑ Swelling ❑ Weakness

7. Since your pain began, how has it changed?

❑ Decreased ❑ Increased ❑ Stayed the same

8. Are you working? ❑ Full Duty ❑ Light Duty ❑ Not Working

9. Please check the activities that increase, decrease or do not change the pain for which we are treating you:

ACTIVITY	INCREASE PAIN	DECREASE PAIN	NO CHANGE
Sitting	❑	❑	❑
Standing	❑	❑	❑
Walking	❑	❑	❑
Lying Down	❑	❑	❑
Changing Positions	❑	❑	❑
Leaning Forward	❑	❑	❑

10. Mark the following signs and/or symptoms you experience:

Constitutional:
- ❑ Chills
- ❑ Fatigue
- ❑ Fever
- ❑ Night Sweats
- ❑ Weakness
- ❑ Weight Gain
- ❑ Weight Loss

HEENT:
- ❑ Blurred Vision
- ❑ Double Vision
- ❑ Difficulty or Pain with Swallowing
- ❑ Ear Drainage
- ❑ Facial Pain
- ❑ Headache
- ❑ Hearing Loss
- ❑ Hoarseness
- ❑ Nasal Congestion
- ❑ Ringing in Ears
- ❑ Vertigo
- ❑ Vision Loss

Respiratory:
- ❑ Chest Pain (Respiratory)
- ❑ Cough
- ❑ Recent Infections
- ❑ Known TB Exposure
- ❑ Wheezing
- ❑ Difficulty or Pain with Breathing

Cardiovascular:
- ❑ Chest Pain
- ❑ Heart Murmur
- ❑ Leg Swelling
- ❑ Syncope
- ❑ Irregular Heartbeat/ Palpitations

Gastrointestional:
- ❑ Abdominal Pain
- ❑ Constipation
- ❑ Black Tarry Stools
- ❑ Diarrhea
- ❑ Heartburn
- ❑ Jaundice
- ❑ Loss of Appetite
- ❑ Nausea
- ❑ Vomiting

Genitourinary:
- ❑ Pain with Urination
- ❑ Frequent Urination
- ❑ Blood in Urine
- ❑ Urge Incontinence
- ❑ Urinary Incontinence

Metabolic/Endocrine:
- ❑ Cold Intolerant
- ❑ Hair Loss
- ❑ Heat Intolerant

Neurological:
- ❑ Difficulty Walking
- ❑ Dizziness
- ❑ Poor Coordination
- ❑ Memory Loss
- ❑ Muscle Weakness
- ❑ Seizures
- ❑ Tremors

Psychiatric:
- ❑ Anxiety
- ❑ Depression
- ❑ Insomnia

Integumentary:
- ❑ Contact Allergy
- ❑ Itchy Skin
- ❑ Rash
- ❑ Skin Infections
- ❑ Skin Lesion

Hematologic:
- ❑ Bleeding
- ❑ Bruising

Immunological:
- ❑ Asthma
- ❑ Bee Sting Allergies
- ❑ Environmental Allergies
- ❑ Food Allergies
- ❑ Seasonal Allergies
- ❑ Latex Allergy

❑ None of these apply to me

Current Medications

Please indicate which (if any) of the following blood-thinners you are taking:
❑ Aggrenox ❑ Coumadin / Warfarin ❑ Effient ❑ Lovenox ❑ Plavix ❑ Pletal ❑ Pradaxa ❑ Prasugrel
❑ Ticlid ❑ Other_____

Please list all medications you are currently taking. Attach an additional sheet if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Allergies

Do you have any known drug allergies? ❑ Yes ❑ No

If so, please list all medications you are allergic to.

Medication Name	Allergic Reaction Type (Rash, Hives, wheezing, other)

Topical Allergies: ❑ Iodine ❑ Latex ❑ Tape Are you allergic to shellfish or contrast dye? ❑ Yes ❑ No

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medicine
- ❑ Cancer - Type _____
- ❑ Diabetes - Type I _____
- ❑ Diabetes - Type II _____
- ❑ HIV / AIDS

Head/Eyes/Ears/Nose/Throat
- ❑ Headaches
- ❑ Migraines
- ❑ Head Injury
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Glaucoma

Cardiovascular/Hematologic
- ❑ Anemia
- ❑ Bleeding Disorders
- ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Mitral Valve Prolapse
- ❑ Murmur
- ❑ Phlebitis
- ❑ Poor Circulation
- ❑ Stroke
- ❑ Coronary Artery Disease

Respiratory
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema/COPD
- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Valley Fever

Gastrointestinal
- ❑ Bowel Incontinence
- ❑ GERD (Acid Reflux)
- ❑ Gastrointestinal Bleeding
- ❑ Constipation

Musculoskeletal
- ❑ Amputation
- ❑ Bursitis
- ❑ Carpal Tunnel Syndrome
- ❑ Chronic Low Back Pain
- ❑ Chronic Neck Pain
- ❑ Chronic Joint Pain
- ❑ Fibromyalgia
- ❑ Joint Injury
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Phantom Limb Pain
- ❑ Rheumatoid Arthritis
- ❑ Tennis Elbow
- ❑ Vertebral Compression Fracture

Genitourinary/Nephrology
- ❑ Bladder Infection(s)
- ❑ Dialysis
- ❑ Kidney Infection(s)
- ❑ Kidney Stones
- ❑ Urinary Incontinence

Hepatic
- ❑ Hepatitis A (active / inactive / unsure)
- ❑ Hepatitis B (active / inactive / unsure)
- ❑ Hepatitis C (active / inactive / unsure)

Neuropsychological
- ❑ Alcohol Abuse
- ❑ Alzheimer Disease
- ❑ Bipolar Disorder
- ❑ Depression
- ❑ Epilepsy
- ❑ Prescription Drug Abuse
- ❑ Multiple Sclerosis
- ❑ Paralysis
- ❑ Peripheral Neuropathy
- ❑ Schizophrenia
- ❑ Seizures
- ❑ Street Drugs
- ❑ Reflex Sympathetic Dystrophy/CRPS
- ❑ Other Diagnosed Conditions

_____
_____

Surgical History

List Any Past Surgeries and Date ❑ **None** ❑ **See Attached List**

_____

_____

_____

_____

_____

Family History

❑ **None** ❑ **Unknown/Adopted OR indicate if any of your blood relatives have had any of the following conditions**

❑ Bleeding Disorder	❑ Diabetes	❑ Muscle Disorders	❑ Respiratory Disease
❑ Blood Disease	❑ Heart Disease	❑ Nerve Disorders	❑ Rheumatiod Arthritis
❑ Cancer: type:_____	❑ High Blood Pressure	❑ Osteoarthritis	❑ Scoliosis
❑ Depression	❑ Kidney Disease	❑ Osteoporosis	❑ Other:_____

Social History

Tobacco Use: ❑ Non Smoker ❑ Former Smoker _____Year Quit ❑ Current Smoker _____# Packs/Day _____# Years
❑ Cigarette ❑ Cigar ❑ Smokeless Tobacco ❑ Other_____
Alcohol Use: ❑ Never ❑ Rarely ❑ Weekly ❑ Daily
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other
Level of education completed? ❑ High School ❑ 1–4 yrs College ❑ >4 yrs College

Work History

Do you work? ❑ Full-time ❑ Part-time ❑ Disabled ❑ Retired ❑ NA
Are you on Light Duty? ❑ Yes ❑ No ❑ NA
What is your occupation? _____
Do you enjoy your work? ❑ Yes ❑ No ❑ NA

Patient's Signature _____